FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042879

Facility Name: PROVENA MCAULEY MANOR

Address: 400 W. SULLIVAN ROAD (Number) AURORA (City) 60506 (Zip Code)

County: KANE

Telephone Number: (630) 859-3700 **Fax #** (630) 264-1862

IDPA ID Number: 371127787012

Date of Initial License for Current Owners: 12/01/97

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Lynda Olinski **Telephone Number:** (708) 478-7916

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Michael R. Gordon
(Title) VP of Finance, CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	87	Skilled (SNF)	87	31,842	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	87	TOTALS	87	31,842	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	927	18,577	6,402	25,906	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	927	18,577	6,402	25,906	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.36%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/1/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 45 and days of care provided 6,402

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	181,290	23,534	7,525	212,349		212,349		212,349			1
2	Food Purchase		159,068		159,068		159,068	(11,556)	147,512			2
3	Housekeeping	123,133	24,854		147,987		147,987		147,987			3
4	Laundry	13,335	10,848	32,414	56,597		56,597	(20,210)	36,387			4
5	Heat and Other Utilities			133,461	133,461		133,461	638	134,099			5
6	Maintenance	89,434	7,125	75,250	171,809		171,809	31,326	203,135			6
7	Other (specify):* Pastoral Care/Develop	43,671	2,959	49,167	95,797		95,797	(32,349)	63,448			7
8	**TOTAL General Services**	450,863	228,388	297,817	977,068		977,068	(32,151)	944,917			8
	B. Health Care and Programs											
9	Medical Director			31,445	31,445		31,445		31,445			9
10	Nursing and Medical Records	1,576,273	123,180	612,824	2,312,277		2,312,277		2,312,277			10
10a	Therapy			390,340	390,340		390,340		390,340			10a
11	Activities	61,266	1,621	5,808	68,695		68,695	1,120	69,815			11
12	Social Services	33,774	53	558	34,385		34,385		34,385			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,671,313	124,854	1,040,975	2,837,142		2,837,142	1,120	2,838,262			16
	C. General Administration											
17	Administrative	302,256	1,028	423,974	727,258		727,258	(207,342)	519,916			17
18	Directors Fees											18
19	Professional Services			15,477	15,477		15,477	218,932	234,409			19
20	Dues, Fees, Subscriptions & Promotions			45,247	45,247		45,247	1,750	46,997			20
21	Clerical & General Office Expenses		16,303	26,446	42,749		42,749	(8,065)	34,684			21
22	Employee Benefits & Payroll Taxes			524,587	524,587		524,587	71,330	595,917			22
23	Inservice Training & Education			13,377	13,377		13,377	4,209	17,586			23
24	Travel and Seminar			4,166	4,166		4,166	3,707	7,873			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			52,686	52,686		52,686	4,142	56,828			26
27	Other (specify):* Bad Debt			50,400	50,400		50,400	(19,691)	30,709			27
28	**TOTAL General Administration**	302,256	17,331	1,156,360	1,475,947		1,475,947	68,972	1,544,919			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,424,432	370,573	2,495,152	5,290,157		5,290,157	37,941	5,328,098			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PROVENA MCAULEY MANOR #0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			280,186	280,186		280,186	77,928	358,114			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							75,976	75,976			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							8,163	8,163			34
35	Rent-Equipment & Vehicles			29,540	29,540		29,540	827	30,367			35
36	Other (specify):* Loss on Asset Disposals			756	756		756		756			36
37	**TOTAL Ownership**			310,482	310,482		310,482	162,894	473,376			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			362,244	362,244		362,244		362,244			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			47,763	47,763		47,763		47,763			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			410,007	410,007		410,007		410,007			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,424,432	370,573	3,215,641	6,010,646		6,010,646	200,835	6,211,481			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(12,813)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(20,210)	4		8
9	Non-Straightline Depreciation	7,930	30		9
10	Interest and Other Investment Income	(24,843)	32		10
11	Discounts, Allowances, Rebates & Refunds	(13,687)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50,400)	27		24
25	Fund Raising, Advertising and Promotional	(8,746)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,769)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	357,274		34
35	Other- Attach Schedule	(33,670)		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 323,604		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 200,835		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

PROVENA MCAULEY MANOR

ID# 0042879

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Development Salares	$ (12,810)	7	1
2	Development Activities/Fundraising	0	7	2
3	Development Miscellaneous	(19,539)	7	3
4	Development Benefits	(1,321)	22	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(33,670)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(12,813)	1,257	0	0	0	0	0	0	0	0	0	(11,556)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(20,210)	0	0	0	0	0	0	0	0	0	0	(20,210)	4
5	Heat and Other Utilities	0	638	0	0	0	0	0	0	0	0	0	638	5
6	Maintenance	0	228	31,098	0	0	0	0	0	0	0	0	31,326	6
7	Other (specify):*	(32,349)	0	0	0	0	0	0	0	0	0	0	(32,349)	7
8	**TOTAL General Services**	(65,372)	2,123	31,098	0	0	0	0	0	0	0	0	(32,151)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1,120	0	0	0	0	0	0	0	0	0	1,120	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1,120	0	0	0	0	0	0	0	0	0	1,120	16
	C. General Administration													
17	Administrative	0	(179,476)	(27,866)	0	0	0	0	0	0	0	0	(207,342)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	17,081	201,851	0	0	0	0	0	0	0	0	218,932	19
20	Fees, Subscriptions & Promotions	(8,746)	10,496	0	0	0	0	0	0	0	0	0	1,750	20
21	Clerical & General Office Expenses	(13,687)	5,622	0	0	0	0	0	0	0	0	0	(8,065)	21
22	Employee Benefits & Payroll Taxes	(1,321)	27,191	45,460	0	0	0	0	0	0	0	0	71,330	22
23	Inservice Training & Education	0	4,209	0	0	0	0	0	0	0	0	0	4,209	23
24	Travel and Seminar	0	3,707	0	0	0	0	0	0	0	0	0	3,707	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	4,142	0	0	0	0	0	0	0	0	0	4,142	26
27	Other (specify):*	(50,400)	0	30,709	0	0	0	0	0	0	0	0	(19,691)	27
28	**TOTAL General Administration**	(74,154)	(107,028)	250,154	0	0	0	0	0	0	0	0	68,972	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(139,526)	(103,785)	281,252	0	0	0	0	0	0	0	0	37,941	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	7,930	0	69,998	0	0	0	0	0	0	0	0	77,928	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,843)	0	100,819	0	0	0	0	0	0	0	0	75,976	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	8,163	0	0	0	0	0	0	0	0	8,163	34
35	Rent-Equipment & Vehicles	0	0	827	0	0	0	0	0	0	0	0	827	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(16,913)	0	179,807	0	0	0	0	0	0	0	0	162,894	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(156,439)	(103,785)	461,059	0	0	0	0	0	0	0	0	200,835	45

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		2	Food	$	Provena Senior Services	100.00%	$ 1,257	$ 1,257	1
2	V		5	Utilities		Provena Senior Services	100.00%	638	638	2
3	V		6	Maintenance - Other		Provena Senior Services	100.00%	228	228	3
4	V		11	Activities-Special Events		Provena Senior Services	100.00%	1,120	1,120	4
5	V		17	Admin - Misc. Other	270,721	Provena Senior Services	100.00%	2,661	(268,060)	5
6	V		17	Administrative Salaries		Provena Senior Services	100.00%	88,584	88,584	6
7	V		19	Professional Services		Provena Senior Services	100.00%	17,081	17,081	7
8	V		20	Dues,Subscriptions		Provena Senior Services	100.00%	10,496	10,496	8
9	V		21	Clerical Supplies		Provena Senior Services	100.00%	5,622	5,622	9
10	V		22	Employee Benefits		Provena Senior Services	100.00%	27,191	27,191	10
11	V		23	Education/Conference		Provena Senior Services	100.00%	4,209	4,209	11
12	V		24	Travel		Provena Senior Services	100.00%	3,707	3,707	12
13	V		26	Insurance		Provena Senior Services	100.00%	4,142	4,142	13
14	Total				$ 270,721			$ 166,936	$ * (103,785)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Bad Debt	$	Provena Senior Services	100.00%	$ 30,709	$ 30,709	15
16	V	30	Depreciation		Provena Senior Services	100.00%	1,673	1,673	16
17	V	32	Interest		Provena Senior Services	100.00%	100,819	100,819	17
18	V	34	Rent - Facility		Provena Senior Services	100.00%	8,163	8,163	18
19	V	35	Rent - Equipment		Provena Senior Services	100.00%	827	827	19
20	V	17	Admin Salaries	90,612	Provena Health Services	100.00%	58,731	(31,881)	20
21	V	22	Employee Benefits		Provena Health Services	100.00%	21,277	21,277	21
22	V	30	Depreciation		Provena Health Services	100.00%	68,325	68,325	22
23	V	19	Admin Consulting,Other		Provena Health Services	100.00%	201,851	201,851	23
24	V	17	Information Systems Salaries	62,592	Provena Health Services	100.00%	12,021	(50,571)	24
25	V	22	Information Systems Benefits		Provena Health Services	100.00%	4,407	4,407	25
26	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	5,886	5,886	26
27	V	17	Admin Salaries		Provena Health Services	100.00%	35,593	35,593	27
28	V	22	Employee Benefits		Provena Health Services	100.00%	12,895	12,895	28
29	V	17	Information Systems Salaries		Provena Health Services	100.00%	18,993	18,993	29
30	V	22	Information Systems Benefits		Provena Health Services	100.00%	6,881	6,881	30
31	V	6	Information Systems - Equip Maint		Provena Health Services	100.00%	25,212	25,212	31
32	V	39	Ancillary Services - Other	362,244	Provena Senior Services Pharmacy	100.00%	362,244		32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 515,448			$ 976,507	$ * 461,059	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services
Street Address: 19065 Hickory Creek Drive, Ste 310
City / State / Zip Code: Mokena, IL60448
Phone Number: (708)478-7900
Fax Number: (708)478-5387

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Food	Management Fee Income	4,942,944	16	$ 22,950	$	270,721	$ 1,257	1
2	5	Utilities	Management Fee Income	4,942,944	16	11,646		270,721	638	2
3	6	Maintenance - Other	Management Fee Income	4,942,944	16	4,154		270,721	228	3
4	11	Activities-Special Events	Management Fee Income	4,942,944	16	20,442		270,721	1,120	4
5	17	Admin - Misc. Other	Management Fee Income	4,942,944	16	48,582		270,721	2,661	5
6	17	Administrative Salaries	Management Fee Income	4,942,944	16	1,617,398	1,617,398	270,721	88,584	6
7	19	Professional Services	Management Fee Income	4,942,944	16	311,867		270,721	17,081	7
8	20	Dues,Subscriptions	Management Fee Income	4,942,944	16	191,638		270,721	10,496	8
9	21	Clerical Supplies	Management Fee Income	4,942,944	16	102,640		270,721	5,622	9
10	22	Employee Benefits	Management Fee Income	4,942,944	16	496,473		270,721	27,191	10
11	23	Education/Conference	Management Fee Income	4,942,944	16	76,847		270,721	4,209	11
12	24	Travel	Management Fee Income	4,942,944	16	67,676		270,721	3,707	12
13	26	Insurance	Management Fee Income	4,942,944	16	75,628		270,721	4,142	13
14	27	Bad Debt	Management Fee Income	4,942,944	16	560,691		270,721	30,709	14
15	30	Depreciation	Management Fee Income	4,942,944	16	30,542		270,721	1,673	15
16	32	Interest	Management Fee Income	4,942,944	16	1,840,794		270,721	100,819	16
17	34	Rent - Facility	Management Fee Income	4,942,944	16	149,043		270,721	8,163	17
18	35	Rent - Equipment	Management Fee Income	4,942,944	16	15,101		270,721	827	18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,644,112	$ 1,617,398		$ 309,127	25

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Health Services
Street Address: 9223 West St. Francis Road
City / State / Zip Code: Frankfort, IL 60423
Phone Number: (815)469-4888
Fax Number: (815)469-4864

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Admin Salaries	Operating Expense	1,101,876		$ 714,188	$ 714,188	90,612	$ 58,731	1
2	22	Employee Benefits	Operating Expense	1,101,876		258,738		90,612	21,277	2
3	30	Depreciation	Operating Expense	1,101,876		830,857		90,612	68,325	3
4	19	Admin Consulting,Other	Operating Expense	1,101,876		2,454,578		90,612	201,851	4
5	17	Information Systems Salaries	Operating Expense	761,172		146,180	146,180	62,592	12,021	5
6	22	Information Systems Benefits	Operating Expense	761,172		53,593		62,592	4,407	6
7	6	Information Systems - Equip Mai	Operating Expense	761,172		71,577		62,592	5,886	7
8	17	Admin Salaries	Direct Cost	1,101,876		432,829	432,829	90,612	35,593	8
9	22	Employee Benefits	Direct Cost	1,101,876		156,806		90,612	12,895	9
10	17	Information Systems Salaries	Direct Cost	761,172		230,974	230,974	62,592	18,993	10
11	22	Information Systems Benefits	Direct Cost	761,172		83,678		62,592	6,881	11
12	6	Information Systems - Equip Mai	Direct Cost	761,172		306,605		62,592	25,212	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,740,603	$ 1,524,171		$ 472,072	25

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Provena Senior Services Pharmacy
Street Address: 1475 Harvard Drive
City / State / Zip Code: Kankakee, IL 60901
Phone Number: (815)928-6141
Fax Number: (815)946-3238

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	Ancillary Services - Other	Direct Cost			$	$		$ 362,244	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 362,244	25

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	Provena Senior Services										75,976	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 75,976	14
15	TOTALS (line 9+line14)						$	$			$ 75,976	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	94,396	8
2000	97,543	9
2001	94,396	10
2002	105,591	11
2003		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PROVENA MCAULEY MANOR COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0042879

CONTACT PERSON REGARDING THIS REPORT Lynda Olinski

TELEPHONE 708-478-7916 FAX #: 708-478-5387

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87			1986	$ 4,218,962	$ 168,758	25	$ 168,758	$	$ 1,096,930	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1987	36,401		15			36,401	9
10	VARIOUS			1988	47,074	592	16	592		4,933	10
11	VARIOUS			1989	20,698	982	15	982		20,698	11
12	VARIOUS			1990	25,276	1,211	13	1,211		24,442	12
13	VARIOUS			1991	44,027	2,775	15	2,775		37,608	13
14	VARIOUS			1992	120,907	7,415	14	7,415		93,223	14
15	VARIOUS			1993	133,363	7,855	13	7,855		103,764	15
16	VARIOUS			1994	32,534	836	11	836		28,854	16
17	VARIOUS			1995	22,015		8			22,015	17
18	VARIOUS			1996	70,791	4,318	8	4,318		39,624	18
19	VARIOUS			1997	20,454	181	6	181		19,115	19
20	VARIOUS			1999	35,104	3,707	6	3,707		27,176	20
21	VARIOUS			2000	43,053	3,459	10	3,459		15,565	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DESC: LANDSCAPE ARCHITECTURE SERVICES	2001	$ 2,823	$ 565	5	$ 565	$	$ 1,976	37
38	DESC: LANDSCAPING	2001	22,255	2,226	10	2,226		7,789	38
39	DESC: BOHR ROOFING REPAIRS	2001	168	34	5	34		118	39
40	DESC: ROOF REPAIRS	2001	390	78	5	78		273	40
41	DESC: RGB ARCHITECTURAL SERVICES (4/27/01)	2001	4,579	916	5	916		3,205	41
42	DESC: REPLACE VALVES, REPAIR LEAKING FLANG	2001	1,476	295	5	295		1,033	42
43	DESC: HARDWARE	2001	605	121	5	121		423	43
44	DESC: PAINT & WALLPAPER BORDER	2001	263	53	5	53		184	44
45	DESC: 4" VINYL COVERED BASE (1 CARTON-WARM	2001	87	17	5	17		61	45
46	DESC: VENTILATION SYSTEM	2001	2,764	553	5	553		1,934	46
47	DESC: BUILDING PERMIT - MECHANICAL WORK	2001	395		2			395	47
48	DESC: INSTALLATIOM OF DOOR HARDWARE	2001	1,129	226	5	226		790	48
49	DESC: COMBUSTION AIR DUCT SYSTEM	2001	10,835	1,084	10	1,084		3,792	49
50	DESC: REPAIR ROOF	2001	808	162	5	162		565	50
51	DESC: RGB CONSULTING (09/01/01 - 09/28/01)	2001	270	54	5	54		189	51
52	DESC: ELECTRICAL WORK	2001	10,368	2,074	5	2,074		7,257	52
53	DESC: LIGHT TOWER	2001	475	48	10	48		166	53
54	DESC: INSTALL BALLAST LIGHTING	2001	4,513	903	5	903		3,159	54
55	DESC: PARKING LOT ASPHALT	2001	29,120	3,640	8	3,640		12,740	55
56	DESC: SOD/TOPSOIL	2001	2,056	206	10	206		720	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,966,034	$ 215,340		$ 215,340	$	$ 1,617,118	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,966,034	$ 215,340		$ 215,340	$	$ 1,617,118	1
2	DESC: INSTALL RPZ	2002	7,981	798	1995.25	798		1,995	2
3	DESC: SHEET VINYL FLOORING IN 3 ELEVATORS	2002	1,685	337	842.5	337		843	3
4	DESC: WALL REPAIRS / PAINTING	2002	4,275	855	2137.5	855		2,138	4
5	DESC: ROOF AND DECK REPLACEMENT	2002	4,639	464	1159.75	464		1,160	5
6	DESC: DRYWALL REPLACEMENT / PAINTING	2002	1,000	200	500	200		500	6
7	DESC: BORDER WALLCOVERING	2002	960	192	480	192		480	7
8	DESC: PAINTING AND ERPAIR OF COORIDORS/HAL	2002	6,213	1,243	2485.2	1,243		2,485	8
9	DESC: PAINTING CUSTOMER LOUNGE, PATIENTS'	2002	1,200	240	479.8	240		480	9
10	DESC: REPLACE HOT WATER BOILER AND HEATERS	2002	14,331	1,433	2866.2	1,433		2,866	10
11	DESC: NEW WALK PATHS	2002	19,377	2,422	4844.12	2,422		4,844	11
12	DESC: REPLACEMENT FLOORING ALTZHEIMER UNIT	2002	11,967	2,393	4786.84	2,393		4,787	12
13	DESC: REPLACEMENT FLOORING FOR FAMILY LOUN	2002	1,258	252	503.2	252		503	13
14	DESC: FREIGHT	2002	260	52	104	52		104	14
15	DESC: BORDER WALL COVERINGS	2002	85	17	34	17		34	15
16	DESC: ROOF REPAIRS	2002	3,800	253	506.66	253		507	16
17									17
18	DESC: CARPET RELACEMENT- LOUNGE AND ADMINI	2003	10,515	2,103	5	2,103		3,154	18
19	DESC: REPIPE CIRCULATING LINE AND INSTALL	2003	3,000	300	10	300		450	19
20	DESC: VACUUM PUMP	2003	1,847	369	5	369		554	20
21	DESC: FREON	2003	1,511	302	5	302		453	21
22	DESC: 50 GALLON ELECTRIC WATER HEATER	2003	4,758	476	10	476		714	22
23	DESC: PRIVATE CABLE TV SYSTEM	2003	22,812	2,281	10	2,281		3,422	23
24	DESC: PAINT ROOMS	2003	15,000	3,000	5	3,000		4,500	24
25	DESC: REFRIGERATION/COOLING CLEANING AND A	2003	3,355	671	5	671		1,007	25
26	DESC: BORDER WALLCOVERING	2003	425	85	5	85		128	26
27	DESC: 2ND FLOOR NURSES STATION	2003	26,960	1,797	15	1,797		1,797	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,135,247	$ 237,876		$ 237,876	$	$ 1,657,021	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,135,247	$ 237,876		$ 237,876	$	$ 1,657,021	1
2	DESC: PLEATED SHADES	2004	10,048	2,010	5	2,010		2,010	2
3	DESC: WALL SCONCES AND BORDER	2004	666	67	10	67		67	3
4	DESC: VOICE MAIL	2004	2,307	115	10	231	115	231	4
5	DESC: CCTV SYSTEM UPGRADE	2004	2,690	90	15	179	90	179	5
6	DESC: ALUMINUM DOORS	2004	4,500	113	20	225	113	225	6
7	DESC: CALLXPRESS SOFTWARE	2004	3,590	359	5	718	359	718	7
8	DESC: ELEVATOR MOTOR	2004	2,900	73	20	145	73	145	8
9	DESC: ROOF REPAIR AND MAINTENANCE	2004	1,816	182	5	363	182	363	9
10	DESC: RESURFACE PAVING FOR PARKING LOT & R	2004	14,900	931	8	1,863	931	1,863	10
11	DESC: CONTROL RELACEMENT ON BOILER & CHILL	2004	47,000	2,350	10	4,700	2,350	4,700	11
12	DESC: ALUMINUM DOOR W/ SIDELITE FRAME	2004	1,900	95	10	190	95	190	12
13	DESC: REPLACE CONCRETE 8FT x 11FT IN ENTRY	2004	1,850	62	15	123	62	123	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,229,414	$ 244,320		$ 248,689	$ 4,368	$ 1,667,835	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 273,009	$ 26,993	$ 26,993	$	10	$ 211,591	71
72	Current Year Purchases	53,251	3,590	7,151	3,561	7	7,151	72
73	Fully Depreciated Assets	529,086					529,086	73
74	Home Office Allocation			69,998	69,998			74
75	TOTALS	$ 855,346	$ 30,583	$ 104,142	$ 73,559		$ 747,829	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 FORD ELDORADO	1999	$ 42,261	$ 5,283	$ 5,283	$	8	$ 13,207	76
77										77
78										78
79										79
80	TOTALS			$ 42,261	$ 5,283	$ 5,283	$		$ 13,207	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,127,021	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 280,186	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 358,114	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 77,927	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,428,870	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation Home Office				8,163			5
6								6
7	TOTAL				$ 8,163 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 30,367 Description: Nursing - $28,349.85, Admin - $990.74, Home Office - $827, Diet - $199.22
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a, 3	hrs	$	3,170	$ 165,477	$	3,170	$ 165,477	1
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		251	13,101		251	13,101	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a, 3	hrs		4,057	211,762		4,057	211,762	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				362,244		362,244	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	7,478	$ 390,340	$ 362,244	7,478	$ 752,584	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 8,885,741	$	1
2	Cash-Patient Deposits	102,693		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	8,420,236		3
4	Supply Inventory (priced at)	588,898		4
5	Short-Term Investments			5
6	Prepaid Insurance	7,152		6
7	Other Prepaid Expenses	124,516		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 18,129,236	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	7,836,704		12
13	Land	6,851,272		13
14	Buildings, at Historical Cost	74,980,161		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	13,506,539		16
17	Accumulated Depreciation (book methods)	(40,776,212)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	140,712		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 62,539,176	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 80,668,412	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,746,542	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,611,167		28
29	Short-Term Notes Payable	31,980		29
30	Accrued Salaries Payable	1,849,317		30
31	Accrued Taxes Payable (excluding real estate taxes)	44,053		31
32	Accrued Real Estate Taxes(Sch.IX-B)	240,643		32
33	Accrued Interest Payable	23,513		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Party	988,855		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 6,536,070	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,363,410		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation	143,623		42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,507,033	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,043,103	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 72,625,309	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 80,668,412	$	48

***(See instructions.)**

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 31,464,506	1
2	Restatements (describe):		2
3			3
4	**Adj. To Reconcile Consolidated Equity and Consolidated**		4
5	**Net Income to Nursing Facility Amounts**	419,706	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 31,884,212	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	134,771	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 134,771	17
	B. Transfers (Itemize):		
18	**Transfer Debt to Provena Health**	40,606,326	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 40,606,326	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 72,625,309	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,648,957	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,648,957	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	918,798	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 918,798	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	634	13
14	Non-Patient Meals	12,813	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	438,796	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	25,151	20
21	Other Medical Services		21
22	Laundry	20,210	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 497,604	23
	D. Non-Operating Revenue		
24	Contributions	41,528	24
25	Interest and Other Investment Income***	24,843	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 66,371	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	Purchase Rebates	13,687	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,687	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,145,417	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	977,068	31
32	Health Care	2,837,142	32
33	General Administration	1,475,947	33
	B. Capital Expense		
34	Ownership	310,482	34
	C. Ancillary Expense		
35	Special Cost Centers	362,244	35
36	Provider Participation Fee	47,763	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,010,646	40
41	**Income before Income Taxes (line 30 minus line 40)****	134,771	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 134,771	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,624	2,154	$ 72,189	$ 33.51	1
2	Assistant Director of Nursing	1,216	1,248	33,718	27.02	2
3	Registered Nurses	17,116	18,208	470,161	25.82	3
4	Licensed Practical Nurses	7,582	8,005	176,518	22.05	4
5	Nurse Aides & Orderlies	60,486	65,808	781,905	11.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,004	3,106	41,783	13.45	8
9	Activity Director	2,040	2,160	26,494	12.27	9
10	Activity Assistants	5,295	5,725	34,772	6.07	10
11	Social Service Workers	2,144	2,224	33,774	15.19	11
12	Dietician	2,064	2,160	26,147	12.11	12
13	Food Service Supervisor	3,767	3,913	28,326	7.24	13
14	Head Cook	6,049	6,413	53,580	8.35	14
15	Cook Helpers/Assistants	12,231	12,875	73,237	5.69	15
16	Dishwashers					16
17	Maintenance Workers	5,712	6,766	89,435	13.22	17
18	Housekeepers	13,704	15,145	123,132	8.13	18
19	Laundry	1,284	1,355	13,335	9.84	19
20	Administrator	1,904	2,120	102,502	48.35	20
21	Assistant Administrator	1,408	1,480	33,214	22.44	21
22	Other Administrative	3,913	4,160	69,700	16.75	22
23	Office Manager					23
24	Clerical	8,201	9,045	96,839	10.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral/Developm	2,456	2,720	43,671	16.06	33
34	TOTAL (lines 1 - 33)	163,200	176,790	$ 2,424,432 *	$ 13.71	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	135	$ 7,009	1,3	35
36	Medical Director	$1575/mth	31,446	9,3	36
37	Medical Records Consultant	16	920	10,3	37
38	Nurse Consultant	244	12,211	10,3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	32	1,962	11,3	44
45	Social Service Consultant	10	558	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	437	$ 54,106		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,564	$ 74,829	10,3	50
51	Licensed Practical Nurses	144	5,398	10,3	51
52	Nurse Aides	8	135	10,3	52
53	TOTAL (lines 50 - 52)	1,716	$ 80,361		53

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James Boyle	Administrator	0	$ 80,640
Julie Hughes	Administrator	0	21,862
Administrative Staff	Asst Administrator	0	33,214
Administrative Staff	Human Resource	0	22,181
Administrative Staff	Admissions	0	24,765
Administrative Staff	Reception/Admin Asst	0	68,657
Administrative Staff	Bookkeeper	0	50,938
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 302,256

B. Administrative - Other

Description	Amount
Corporate Service Fee	$ 90,661
Corporate IS Fee	62,592
Mgmt Fee	270,721
Mgmt Fee Interest	0
TOTAL (agree to Schedule V, line 17, col. 3)	$ 423,974
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Expense	Various	$ 1,561
Wellspring/BKD Expense	Various	10,399
Collection Expense	Various	292
Employee Opinoin Survey	Various	1,216
Shredding	Various	2,009
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 15,477

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,162
Unemployment Compensation Insurance	16,610
FICA Taxes	172,814
Employee Health Insurance	155,103
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life Insurance	10,225
Pension	113,640
Employee Recognition	70
Executive Benefits	4,400
Employment Screenings	6,563
Home Office Allocation	71,330
TOTAL (agree to Schedule V, line 22, col.8)	$ 595,917

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 68)	
Dues & Subscriptions	7,444
Advertising & Public Relations	37,802
Home Office Allocation	10,496
Less: Public Relations Expense	( )
Non-allowable advertising	(8,746)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,997

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,166
See Schedule	
Home Office Allocation	3,707
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,873

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PROVENA MCAULEY MANOR # 0042879 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PROVENA MCAULEY MANOR **#** 0042879 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **4222 - Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **Yes** If YES, what is the capacity? **87**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,535** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **47,763**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **12,813**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **not issued yet**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.